

Letters to the Editor

Please e-mail letters for publication to Dr Kamran Abbasi [kamran.abbasi@rsm.ac.uk]. Letters should be no longer than 300 words and preference will be given to letters responding to articles published in the *JRSM*. Our aim is to publish letters quickly. Not all correspondence will be acknowledged.

The demise of nursing

I am disappointed that the *JRSM* published the article by Shields and Watson,¹ and as an Operating Department Practitioner (ODP) I was deeply offended. It is clear the authors are ignorant of the role, training and history of my profession; otherwise they would have known better than to use the surgical role as their example. To appreciate the folly of this example, one must understand that for many years the theatre nursing hierarchy sought to deny ODPs the opportunity to practice in the surgical role—claiming this ‘a purely nursing function’. My profession was then predominantly associated with providing care as part of the anaesthetic team, where patients are initially conscious, often fearful and requiring both psychological and physiological support.

As far back as the 1970s our syllabus incorporated patient care (e.g. ‘Respect the dignity and rights of the patient; Principles of ethics and etiquette; Psychological reaction of patients to surgery and the theatre environment’). These were introduced early and developed throughout the course. Today’s qualification has developed these themes into the modern era, with emphasis on the assessment, planning and evaluation of care. Caring is not genetically implanted into nurses, but taught to all professions with caring responsibilities.

The notion that ODPs are ‘expropriating nurses’ knowledge and skills’ is laughable. We had the first nationally organized course in operating department practice in 1951. In 1989 Bevan² noted ‘only 13.8% of nurses working in theatre had received post-registration training in operating department and/or anaesthetic nursing.’ Throughout the 1990s the NVQ in Operating Department Practice, the ODP’s primary qualification, was taken by many perioperative nurses as their preferred postgraduate qualification.

The authors of the article are at least 30 years out of date with their prejudices and I and my profession deserve a full public apology from both the authors and publishers of this article.

Competing interests BK is a Council Member of The College of Operating Department Practitioners.

Bill Kilvington

E-mail: bill.kilvington@aodp.org

REFERENCES

- 1 Shields L, Watson R. The demise of nursing in the UK: a warning for medicine. *J Roy Soc Med* 2007;100:70–4
- 2 The NHS Management Executive Value for Money Unit. *The Management and Utilisation of Operating Departments*. London: HMSO, 1989

Ankle Brachial Pressure Index

The Editorial by Bhasin and Scott¹ made a persuasive case for measuring the Ankle Brachial Pressure Index (ABPI). They told the reader, five times, that this was a ‘quick, easy, simple, accurate, non-invasive, tool,’ so I couldn’t wait to rush to the surgery to measure this entity. However, the article didn’t tell me what equipment, if any, I would need nor how to derive the index. The reader was told that the topic is either ‘briefly covered in most undergraduate text books’ (but mine are 40 years old) or mentioned a reference that is not available in my local hospital library (if I could only find somewhere to park). Consequently I could only guess about the meaning of the information in Table 1 and the patients whose peripheral vascular disease I might have diagnosed have long since shuffled off. I eventually tracked something down in Wikipedia.

I realize that an Editorial must be succinct but it would be helpful when an unfamiliar method is being eulogized that a couple of lines were set aside to describe it in outline.

Competing interests None declared.

J G Jones

Woodlands, Rufforth, York YO23 3QF

E-mail: johngareth423@btinternet.com

REFERENCE

- 1 Bhasin N, Scott DJA. Ankle Brachial Pressure Index: identifying cardiovascular risk and improving diagnostic accuracy. *J Roy Soc Med* 2007;100:4–5

Response to Scientific journals are ‘faith based’: is there a science behind peer review?

Linkov *et al.*¹ criticize the lack of scientific rigour in peer review research by writing a non-evidence-based piece themselves. A literature search would have identified an increasing body of scientific research on evaluating peer review and the publication process.^{2,3} Since 1989 there have been five international congresses on peer review and biomedical publication, organized by Drummond Rennie at

JAMA, where some research in this area is presented.⁴ Admittedly, it is surprising that progress has been slow in this important research area, but these authors should not be so quick to dismiss this valuable body of work. They misquote the review by Jefferson *et al.*⁵ by saying that they only found 19 scientifically sound studies on peer review. That review did focus on 19 papers, but it only included studies looking at the effectiveness of peer review. There are many more scientifically sound studies on the subject of peer review. So the use of scientific method is not 'almost non-existent' in the publication process, but I agree more rigorous research is needed. Randomized controlled trials have been done and I hope they will continue. However, peer review research should not be limited to randomized controlled trials. More extensive rigorous qualitative research is needed to unpack some of the more complex issues which are not suitable for study by randomized controlled trials. We also need to agree on the objectives of peer review and develop appropriate validated tools that can measure its effects. The BMJ Publishing Group now has an extensive programme of research into evaluating the publishing process both in-house and in collaboration with external researchers (www.bmjresearch.com).⁶ More research funds are needed to help support researchers and journals wanting to conduct research with the aim of improving the publishing process.

Competing interests SS is employed by the BMJ Publishing Group to conduct research on peer review and publishing.

Sara Schroter

Senior researcher, BMJ Publishing Group
E-mail: sschroter@bmj.com

REFERENCES

- 1 Linkov F, Lovalekar M, LaPorte R. Scientific journals are 'faith based': is there science behind peer review? *J Roy Soc Med* 2006;**99**:596–8
- 2 Godlee F, Jefferson T, eds. *Peer review in health sciences*. Second edition. London: BMJ Books, 2003.
- 3 Smith R. *The trouble with medical journals*. London: Royal Society of Medicine Press Ltd, 2006.
- 4 Fister K. At the frontier of biomedical publication: Chicago 2005. *BMJ* 2005;**331**:838–40.
- 5 Jefferson T, Alderson P, Wager E, Davidoff F. Effects of peer review: A systematic review. *JAMA* 2002;**287**:2784–6.
- 6 Tite L, Schroter S. Evidence based publishing. *BMJ* 2006;**333**:366.

Feeling the skin

I read Dr Cox's lovely squib '*Palpation of the skin—an important issue*' in December's *JRSM*¹ (2006;**99**:598–600) with a sense of pride and wistfulness.

I was fortunate to be trained at University of Pennsylvania School of Medicine (Penn) in Philadelphia by doctors who emphasized always touching a patient—somehow and somewhere—when interviewing and/or examining them. This was reinforced later on by my teachers of dermatology at Penn, who included (*mirabile dictu*) Walter Shelley, Albert Kligman, James Leyden, M Samitz, and many others.

The simple act of touching a patient reinforces the humanity of what is an unpleasant situation for a patient, and makes the all-important bond between patient and doctor very concrete and very immediate.

It drives me crazy when I'm in the clinic at Penn or elsewhere and I have to repeatedly urge Derm Residents (who should know better) and the med students (who quickly do learn better under my lashings) to touch a patient, both for diagnostic information as well as for a personal communication of concern and empathy.

I know of dermatologists who were trained never to even shake hands with a patient upon meeting the person, much less touch and palpate their skin. Such an attitude is foreign and unacceptable to me, and verges on (no, reaches) the repugnant and imbecilic!

I cannot—and never will—understand why many doctors and dermatologists still believe that they are 'going to catch something bad' by touching a patient. If teaching them by means of Dr Cox's trenchant missive won't work, then perhaps a crack with a bat (baseball or cricket) might be in order.

Competing interests None declared.

Robert I Rudolph

Dermatology, University of Pennsylvania
E-mail: r-rudolph@comcast.net

REFERENCE

- 1 Cox NH. Palpation of the skin—an important issue. *J Roy Soc Med* 2006;**99**:598–600